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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations #92542 and #93366. A revised copy of the 2567 was sent to the provider on 12/2/15.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 16 residents. Based on observation, interview and record review, the facility failed to notify the physician of 2 abnormal blood pressures for 1 of 5 residents reviewed for unnecessary medications. (#8)

Findings included:

- Resident #8's quarterly (MDS) Minimum Data Set assessment, dated 6/18/15, indicated the resident had severely impaired cognition with a (BIMS) Brief Interview for Mental Status score of 6, independent with eating, and required limited assistance with all other (ADLs) Activities of Daily Living. The assessment indicated the resident received insulin, antidepressive (drug used for treatment of depression) and diuretic (medication to promote the formation and excretion of urine) medications.

The quarterly MDS, dated 9/3/15, indicated the same except the resident also received antipsychotic and antianxiety medications.

The 9/3/15 care plan included the (BBW) Black Box Warnings for the resident's medications that required warning and side effects for the resident's mediations. The care plan lacked instructions regarding the resident's use of medications used to control blood pressure.

Review of the 11/13/15 physician's orders

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revealed diagnoses including atrial fibrillation (irregular heartbeat), coronary artery disease (abnormal condition that may affect the flow of oxygen to the heart), Diabetes Mellitus (when the body can't use glucose, the body can not make enough insulin or the body can't respond to the insulin), hypertension, and congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), and indicated the resident received the following medications:

Aldactone (diuretic used to help with lowering blood pressure),12.5 (mg) milligram, daily, initiated 3/17/15.

Norvasc (blood pressure medication), 5 mg, daily, initiated 3/17/15.

Tekturna (blood pressure medication), 75 mg, daily, initiated 3/17/15.

Review of the resident's blood pressures revealed the following abnormal blood pressures:

10/1/15 =73/46.
10/27/15 =87/52

The mayoclinic.org website stated low blood pressure reading of 90 systolic (the higher number) or a diastolic (the lower number) reading of less than 60 is generally considered low blood pressure.

On 11/18/15 at 825 AM, Nurse C administered several medications to the resident and the

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F 157	Continued From page 3 resident took the pills one at a time. On 11/19/15 at 4:00 PM, Nurse N verified the lack of nursing documentation of follow up for the 2 abnormal blood pressures. On 11/19/15 at 4:05 PM, Administrative Nurse A verified nursing should report, to the physician, a blood pressure that is so low. He/she stated the physician had not ordered blood pressure parameters until 11/3/15, after the abnormal blood pressures. The facility's blood pressure taking policy directed staff to measure the resident's blood pressure as physician ordered and record the blood pressure in the resident's chart. The facility failed to notify the physician of 2 abnormally low blood pressures for Resident #8.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		

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The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. Based on observation, record review and interview, the facility failed to thoroughly investigate and report to the state agency, an allegation of abuse reported to staff by 1 of 30 residents (#2), and failed to follow the facility's policy for reporting bruises of unknown origin through the appropriate facility staff for 1 of 6 residents.

Findings included:

- Resident #2's quarterly (MDS) Minimum Data Set assessment, dated 6/18/15, indicated the

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resident usually understands others and was usually understood, had short/long term memory problems with severely impaired decision making skill, and experienced delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue). The assessment indicated the resident independent with locomotion, required limited assistance with bed mobility, extensive assistance with transfers, walking in room, toileting, hygiene and received anticoagulants and antidepressive medications.

The 6/24/15 care plan for behaviors directed staff to document any behaviors, hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind), and delusions the resident displays to help the nurse keep the physician informed in order to adjust psychoactive medication doses. The care plan directed staff to provide one on one visits with the resident when behaviors are noted, attempt to determine the cause of behaviors, and alleviate causes if known or suspected.

The 6/25/15 at 3:27 PM, nurse's note indicated staff reported the resident was yelling at his/her roommate. The note indicated the nurse found the resident sitting in his/her wheelchair at the foot of his/her roommate's bed, hitting at the roommate's body, yelling "You need to get outta this bed right now!" Staff removed the resident from the situation, made other staff aware of what had happened, and filed an incident report.

The 6/25/15 at 4:45 PM nurse's note (entered into the electronic system on 6/26/15 at 11:30 AM) stated staff reported the resident told the staff that a man had entered his/her room and raped him/her. The note indicated staff assessed the

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resident's room and there was no one in the resident's room and nothing out of place. The resident was lying in bed with his/her eyes closed and staff completed an incident report.

Review of the nurse's notes revealed no assessment of the resident's status.

The 6/26/15 at 9:20 AM nurse's note indicated staff reported, to the physician, the resident's behavior of the day before.

The 6/26/15 witness statement by Nurse Aide R indicated, when the staff entered the resident's room on 6/25/15, the resident was sitting on the edge of his/her bed, without any clothes or brief on and clinging to the bed pad, and appeared "shook up". The report indicated the resident told staff a man raped her and was still out there. Staff reported the complaint to the nurse and Social Services Staff Q.

The 7/1/15 physician progress note indicated the resident had increased confusion, was doing well overall, and has not had any bothersome delusions since last week.

On 11/16/15 at 2:30 PM, observation revealed the resident sitting on his/her bed. The resident spoke clearly, but was confused and talked about the baby bed that was in the room.

On 11/19/15 at 4:50 AM, observation revealed resident lying in bed, covered with a blanket, eyes closed, and the room door open. Further observation revealed the resident's room at the end of a hall, across from an exit door which could only be viewed within 15 feet of it. Across the hall from the resident's room were offices for

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electronic information and emergency services and observation during the survey revealed those doors were usually closed.

On 11/18/15 at 3:50 PM, Administrative Nurse A stated the facility had not thoroughly investigated and reported the resident's complaint of rape to the police or to the state agency.

On 11/19/15 at 12:50 PM, Social Services Staff Q stated the resident had no history of reporting rape and the family had not heard the resident complain of rape before. Social Services Staff Q stated he/she asked aides if they had observed anything unusual and they reported nothing unusual had happened.

The facility's 12/2/09 abuse and neglect policy stated the facility will ensure all alleged violations involving mistreatment, neglect or abuse are reported immediately to the administrator and the risk manager, who will begin an immediate investigation of the incident. Within 24 hours of receiving the incident report, the risk manager will report the alleged incident to the appropriate state agency. The policy stated local law enforcement agency may be notified of the suspected abuse.

The facility failed to thoroughly investigate and report, to the appropriate state agency and/or law enforcement, a complaint of alleged abuse reported by Resident #2.

- Resident #13's significant change (MDS) Minimum Data Set assessment, dated 8/11/15, indicated the resident was understood by others, sometimes understands others, had short/long term memory loss, and moderately impaired decision making skill. The assessment indicated

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the resident did not walk, required limited assistance with eating and extensive assistance with all other (ADLs) Activities of Daily Living. The assessment indicated the resident visually impaired, wore glasses, had unsteady balance, (ROM) Range of Motion impairment in all 4 extremities, used a wheelchair, and had no falls and no skin issues.

The 8/15/15 (CAA) Care Area Assessment summary for falls indicated the staff found the resident sitting beside his/her bed and he/she stated he/she rolled over and fell out of bed. The summary indicated the resident did not ambulate or stand without assistance.

The 7/20/15 care plan for skin stated the resident had history of bruises related to self propelling his/her wheelchair and a potential for recurrent bruises. The care plan directed staff to measure and record description of any bruises (location, size (length and width), color, surrounding skin, presence/absence of pain, presence/absence of signs of healing), and report any bruises to the nurse.

The medical record revealed the following incidents:

8/30/15 bruises to right elbow and arm. Right elbow: 1.5 (cm) centimeter by 1 cm, 2.5 cm by 2 cm, 9 cm by 6 cm, 1 cm by 1 cm. Right upper arm 3 cm by 3 cm, black and blue, without swelling.

9/24/15 at 9:25 AM, bruise to forehead, black and blue with swelling, measuring 1.5 cm by 2.5 cm, and of unknown origin.

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10/6/15 at 9:35 AM, left eye bruise, measuring 1 cm by 0.5 cm, reddish blue, no swelling, found the bruise this morning, near his/her left eye.

On 11/18/15 at 7:40 AM, observation revealed the resident in a wheelchair in his/her room, fully dressed, with glasses and walking shoes on. Further observation revealed the resident used his/her hands to self propel his/her wheelchair to the dining room.

On 11/18/15 at 8:45 AM, observation revealed Nurse Aide F wheeled the resident from the dining room to the restorative room for exercises and the resident held his/her feet off the floor during the 20 foot ride. Observation revealed no visible bruising.

On 11/18/15 at 12:45 PM, Administrative Staff D stated he/she investigated falls/ incidents when staff report them and nurses are to complete an incident report and send it to the risk manager who investigates the cause. Administrative Staff D stated facility management personnel review incidents and come up with further preventions. Administrative Staff D stated he/she had no prior knowledge of the above incidents and verified the staff failed to report all incidents of bruises of unknown origin.

On 11/18/15 at 1:35 PM, Administrative Nurse A stated the bruise found on 9/24/15 was of unknown origin. Administrative Staff D verified the staff did not report the bruises of unknown origin to the (DON) Director of Nursing or the risk manager, as directed by facility policy, and the staff did not complete an investigation to determine the causal factors to implement preventative measures.

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F 225	Continued From page 10 The facility's 12/2/09 Abuse, Neglect policy directed staff to ensure all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the administrator and the risk manager. The policy stated the risk manager would identify events, such as suspicious bruising of residents, patterns or trends that may constitute abuse. The facility failed to report bruises of unknown origin to the facility's DON or risk manager in order for them to investigate the causes and care plan interventions to potentially prevent further bruising/injuries for Resident #13.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		

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under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 16 residents. Based on observation, record review and interview, the facility failed to develop a comprehensive care plan for 1 of 1 residents who received hospice services. (#36)

Findings included:

- Resident #36's significant change (MDS) Minimum Data Set assessment, dated 10/1/15, indicated the resident had impaired cognition, with a (BIMS) Brief Interview for Mental Status score of 8, and required extensive assistance of 2 staff with bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated the resident received oxygen and hospice services.

The 10/13/15 care plan stated hospice was at the facility 2-3 times a week but did not give direction to staff regarding services provided by hospice.

The 9/24/15 physician orders admitted the resident to hospice services.

The March 2009 Hospice Services agreement stated the facility would create a written plan of care which would reflect the hospice patient and family goals and interventions based on the problems identified in the Hospice Patient assessments.

On 11/17/15 at 12:51 PM, observation revealed

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F 279	Continued From page 12 the resident seated in his/her bed watching television with oxygen in place. On 11/19/15 at 8:44 AM, Nurse N stated the facility did not have a hospice care plan for the resident. On 11/19/15 at 12:38 PM, Administrative Nurse A verified there was not a hospice care plan for the resident. The facility failed to develop a comprehensive care plan for Resident #36, who received hospice care services.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 16 residents. Based on observation, record review and interview, the facility failed to investigate the origin of bruises for 3 of 3 residents reviewed for skin conditions. (#23, #12, #13) Findings included: - Resident #23's quarterly (MDS) Minimum Data	F 309		

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Set assessment, dated 9/17/15, indicated the resident had severe cognitive impairment, with a (BIMS) Brief Interview for Mental Status score of 1, and required extensive assistance of 2 staff for bed mobility, transfer, dressing, and toilet use. The MDS stated the resident had unsteady balance, open lesions and on a turn/reposition program.

The 9/23/15 care plan instructed staff to inspect the resident's skin on bath days and as needed.

On 11/18/15 at 3:26 PM, observation revealed the resident had small bruises on both of his/her hands.

On 11/18/15 at 4:40 PM, Nurse C stated he/she was unaware the resident had bruises on his/her hands. Nurse C stated the nurse aide is to report to the nurse when the resident had bruises and the nurse would assess, measure, fill out an incident report, and report to the risk manager.

On 11/19/15 at 4:40 PM, Administrative Nurse A verified the resident's bruises should have been assessed by the charge nurse and this did not occur.

Upon request, from the surveyor, the facility had no policy regarding bruising or injury of unknown source.

The facility failed to investigate the origin of bruises for Resident #23, who had multiple small bruises on both of his/her hands.

- Resident #12's annual (MDS) Minimum Data Set assessment, dated 10/1/15, indicated the resident had a (BIMS) Brief Interview for Mental

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Status score of 8, which indicated the resident had moderately impaired cognition. The MDS indicated the resident required extensive assistance with transfer and toilet use. The MDS indicated the resident had skin tears.

The 10/12/15 care plan instructed staff to assist the resident with (ADLs) Activities of Daily Living, and to use a sit to stand lift for transfers.

On 11/18/15 at 8:46, observation revealed the resident had dark purple to black discoloration partially down both his/her arms.

On 11/18/15 at 4:40 PM, Nurse C stated he/she completed an incident report after new bruises are noted on the resident, and forwarded the information to the risk manager.

On 11/19/15 at 3:15 PM, Nurse Aide J stated the resident had bruises on his/her hands and left arm for about a month.

On 11/19/15 at 4:40 PM, Administrative Nurse A verified the resident ' s bruises should have been assessed by the charge nurse and this did not occur.

Upon request, from the surveyor, the facility had no policy regarding bruising or injury of unknown source.

The facility failed to investigate the origin of bruises for Resident #12, who had purple to black bruises on his/her hands and left arm.

- Resident #13's significant change (MDS) Minimum Data Set assessment, dated 8/11/15, indicated the resident was understood by others,

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sometimes understands others, had short/long term memory loss, and moderately impaired decision making skill. The assessment indicated the resident did not walk, required limited assistance with eating and extensive assistance with all other (ADLs) Activities of Daily Living. The assessment indicated the resident visually impaired, wore glasses, had unsteady balance, (ROM) Range of Motion impairment in all 4 extremities, used a wheelchair, and had no falls and no skin issues.

The 8/15/15 (CAA) Care Area Assessment summary for falls indicated the staff found the resident sitting beside his/her bed and he/she stated he/she rolled over and fell out of bed. The summary indicated the resident did not ambulate or stand without assistance.

The 7/20/15 care plan for skin stated the resident had history of bruises related to self propelling his/her wheelchair and a potential for recurrent bruises. The care plan directed staff to measure and record description of any bruises (location, size (length and width), color, surrounding skin, presence/absence of pain, presence/absence of signs of healing), and report any bruises to the nurse.

The medical record revealed the following incidents:

8/30/15 bruises to right elbow and arm. Right elbow: 1.5 (cm) centimeter by 1 cm, 2.5 cm by 2 cm, 9 cm by 6 cm, 1 cm by 1 cm. Right upper arm 3 cm by 3 cm, black and blue, without swelling.

9/24/15 at 9:25 AM, bruise to forehead, black and

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blue with swelling, measuring 1.5 cm by 2.5 cm, and of unknown origin.

10/6/15 at 9:35 AM, left eye bruise, measuring 1 cm by 0.5 cm, reddish blue, no swelling, found the bruise this morning, near his/her left eye.

On 11/18/15 at 7:40 AM, observation revealed the resident in a wheelchair in his/her room, fully dressed, with glasses and walking shoes on. Further observation revealed the resident used his/her hands to self propel his/her wheelchair to the dining room.

On 11/18/15 at 8:45 AM, observation revealed Nurse Aide F wheeled the resident from the dining room to the restorative room for exercises and the resident held his/her feet off the floor during the 20 foot ride. Observation revealed no visible bruising.

On 11/18/15 at 12:45 PM, Administrative Staff D stated he/she investigated falls/ incidents when staff report them and nurses are to complete an incident report and send it to the risk manager who investigates the cause. Administrative Staff D stated facility management personnel review incidents and come up with further preventions. Administrative Staff D stated he/she had no prior knowledge of the above incidents and verified the staff failed to report all incidents of bruises of unknown origin.

On 11/18/15 at 1:35 PM, Administrative Nurse A stated the bruise found on 9/24/15 was of unknown origin. Administrative Staff D verified the staff did not report the bruises of unknown origin to the (DON) Director of Nursing or the risk manager, as directed by facility policy, and the

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F 309	Continued From page 17 staff did not complete an investigation to determine the causal factors to implement preventative measures. The facility's 12/2/09 Abuse, Neglect policy directed staff to ensure all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the administrator and the risk manager. The policy stated the risk manager would identify events, such as suspicious bruising of residents, patterns or trends that may constitute abuse. The facility failed to report bruises of unknown origin to the facility's DON or risk manager in order for them to investigate the causes and care plan interventions to potentially prevent further bruising/injuries for Resident #13.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 16 residents of which 6 were reviewed for accidents. Based on observation, interview and record review the facility failed to provide supervision and assistive devices to	F 323		

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prevent accidents for 1 of 6 residents. (#5)

Findings included:

- Resident #5's admission (MDS) Minimum Data Set assessment, dated 1/22/15, indicated the resident usually understands others, had a (BIMS) Brief Interview for Mental Status of 7, indicating severe cognitive impairment. The assessment indicated the resident did not walk, and required limited assistance with locomotion. The MDS indicated the resident had unsteady balance, used a wheelchair, and had no falls.

The 10/22/15 (CAA) Care Area Assessment summary for falls indicated the resident at risk for falls, had impaired balance, but had no falls since April.

The 9/30/15 care plan for falls directed staff to monitor bruising for worsening and report to the charge nurse or physician if noted. The 10/28/15 update directed staff to ensure the resident wore his/her glasses, encourage the resident to attend restorative exercises, place the resident in a fall prevention program, follow facility policy for post fall care and use a sit to stand lift for all transfers. The 11/3/15 update directed staff to keep the resident's bed in lowest position. The 11/6/15 update directed staff to check the resident between 6:00 AM and 6:30 AM to see if he/she is awake and ready to get up so that he/she does not try to get up on his/her own. The 11/9/15 update directed staff to use foot pedals on the wheelchair when transporting the resident.

Review of the medical record revealed the resident was hospitalized 8/17 through 10/9/15.

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The 10/9/15 fall risk assessment indicated the resident at high risk for falls due to poor safety awareness, poor vision and decreased muscular coordination/function.

The 11/8/15 at 10:52 AM, nurse's note stated staff was transporting the resident, in his/her wheelchair, from the dining room when the resident put his/her feet on the floor, causing a sudden stop. The note stated staff was unable to stop the resident's fall and the resident hit his/her head on the floor and sustained a large hematoma to his/her forehead. The note further stated the resident had no deficits of (ROM) Range of Motion, neurological status or vital signs.

The 11/9/15 at 1:25 PM, post fall nurse's note stated the nurses continued to perform neurological checks, and the resident had a very large bruise on his/her forehead and below his/her left eye, but did not complain of pain from the bruises.

The 11/11/15 at 9:39 AM, nurse's note stated the neurological checks, vital signs were within normal limits for this resident and the resident denied pain. A purple and green bruise from the left forehead/eye area down into his/her cheek.

On 11/17/15 at 12:03 PM, observation revealed the resident, in his/her wheelchair, with feet on foot pedals, in the dining room. Further observation revealed Nurse Aide F wheeled the resident, to the restorative room and instructed the resident with exercises, then wheeled the resident into the hall.

On 11/17/15 at 12:03 PM, Nurse Aide F stated the

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resident was hospitalized about a month ago and lost a lot of ability to perform ADLs. Nurse Aide F stated the resident walked prior to hospitalization, but has not since re-admission, and staff used a gait belt, and assistance of one staff when walking with him/her.

On 11/18/15 at 10:50 AM, Nurse Aide J stated the resident can self propel his/her wheelchair, but at times requires staff to push him/her so staff place pedals on the wheelchair.

On 11/18/15 at 2:00 PM, Nurse Aide E stated staff push the resident, in his/her wheelchair, with foot pedals on at all times. Nurse Aide E stated some residents can lift their feet up while being pushed, but with Resident #5, staff should have used foot rests.

On 11/18/15 at 3:47 PM, Nurse C stated when the resident was first re-admitted, from the hospital on 10/9/15, he/she was unable to self propel his/her wheelchair.

On 11/18/15 at 3:50 PM, Administrative Nurse A stated the facility did not have a fall prevention policy. Administrative Nurse A verified staff should have used foot pedals while pushing this resident in his/her wheelchair. Administrative Nurse A stated the 11/8/15 fall out of the wheelchair had not been reported to the state agency.

The facility's 4/18/14 fall assessment policy directed staff to complete the post fall event form and determine potential cause of the fall.

The facility failed to provide interventions, such as wheelchair foot pedals, to prevent Resident #5 from sustaining an injury to his/her forehead from

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F 323	Continued From page 21 a fall while being wheeled in his/her wheelchair by staff.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 16 residents. Based on observation, record review and interview the facility failed to ensure acceptable parameters of nutritional status were maintained for 1 of 3 sampled residents reviewed for nutrition, when staff failed to provide physician ordered nutritional supplements to Resident #20. Findings included: - Resident #20's significant change (MDS) Minimum Data Set assessment, dated 7/8/15 indicated the resident had short and long term memory problems, moderately impaired cognitive skills for daily decision making, and required extensive staff assistance with (ADLs) Activities of Daily Living. The MDS indicated the resident	F 325		

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coughed or choked during meals or when swallowing medications, weighed 104 (lbs) pounds and had weight loss.

The 7/8/15 nutritional (CAA) Care Area Assessment indicated the resident's health condition had changed since his/her recent hospital stay. The CAA indicated the resident had his/her own teeth, received regular diet with thickened liquids, and received Ensure (a nutritional supplement) twice a day for a weight loss.

The 7/15/15 care plan instructed staff to serve the resident a mechanical soft diet, 30 (cc) cubic centimeters of liquid protein daily, and to offer the resident Ensure between meals. The care plan instructed staff to monitor/record the resident's weight weekly on bath day, and notify the physician and family of significant weight change.

The 8/06/15 physician's order instructed staff to serve the resident a Magic Cup (a nutritional supplement that can be eaten as a pudding or frozen as an ice cream. Magic Cups are calorically dense, 260 calories, for the no sugar added vanilla flavor and 290 calories, for all other flavors in one 1/2-cup serving) with all meals for low albumin (blood test used to determine the amount of protein in the blood).

The 8/27/15 registered dietician notes indicated the resident received Magic Cup with meals.

The 10/1/2015 registered dietician's quarterly review indicated the resident received Magic Cup with meals. The review indicated the resident's most recent albumin level was 3.2, which indicated a mild protein depletion.

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On 11/17/15 at 11:36 AM, observation revealed the resident seated in a wheel chair at the dining room table, for the noon meal. Further observation revealed no Magic Cup served to the resident at the noon meal as ordered by the physician..

On 11/18/15 at 7:44 AM, observation revealed the resident seated in a wheel chair at the dining room table, for the breakfast meal. Further observation revealed no Magic Cup served to the resident at the breakfast meal as ordered by the physician.

On 11/18/15 at 9:39 AM, Dietary Staff K verified staff did not provide the resident the Magic Cup supplement on the above observations and stated he/she was unaware the physician ordered the resident to receive a Magic Cup with meals. Dietary Staff K stated the last diet order the kitchen received, on 8/31/15, stated the resident was to receive a mechanical soft diet with nectar thickened liquids and because the resident was eating better he/she just assumed the Magic Cup order had been discontinued. Dietary Staff K stated the resident had not received the Magic Cup since 8/31/15.(79 days)

On 11/18/15 at 10:02 AM, Administrative Nurse A stated when a physician discontinues a dietary order, the nurse is suppose to give dietary a slip stating the order has been discontinued. Administrative Nurse A verified the resident should be receiving magic cup with each meal.

The facility failed to maintain acceptable parameters of nutritional status by not serving, a physician ordered Magic Cup supplement, to

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F 325	Continued From page 24 Resident #20, who had a significant weight loss and low albumin level.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 16 residents, of which 5 were reviewed for unnecessary drugs. Based on observation, interview and record review, the facility failed to provide, for 1 of 5 residents	F 329		

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reviewed for medications, further monitoring after staff obtained 2 abnormal blood pressures. (#8)

Findings included:

- Resident #8's quarterly (MDS) Minimum Data Set assessment, dated 6/18/15, indicated the resident had severely impaired cognition with a (BIMS) Brief Interview for Mental Status score of 6, independent with eating, and required limited assistance with all other (ADLs) Activities of Daily Living. The assessment indicated the resident received insulin, antidepressive (medication used for to treat depression) and diuretic (medication to promote the formation and excretion of urine) medications.

The quarterly MDS, dated 9/3/15, indicated the same except the resident also received antipsychotic and antianxiety medications.

The 3/31/15 care plan included the (BBW) Black Box Warnings for the resident's medications that required warning and side effects for specific mediations or in the chart and on the medication administration record.The care plan lacked instructions regarding the resident's use of blood pressure medications.

Review of the 11/13/15 physician's orders revealed diagnoses including atrial fibrillation (irregular heartbeat), coronary artery disease (abnormal condition that may affect the flow of oxygen to the heart), Diabetes Mellitus (when the body can't use glucose, the body can not make enough insulin or the body can't respond to the insulin), hypertension, and congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), and

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indicated the resident received the following medications:

Aldactone (diuretic used to help with lowering blood pressure),12.5 (mg) milligram, daily, initiated 3/17/15.

Norvasc (blood pressure medication), 5 mg, daily, initiated 3/17/15.

Tekturna (blood pressure medication), 75 mg, daily, initiated 3/17/15.

Review of the resident's blood pressures revealed the following abnormal blood pressures:

10/1/15 =73/46.
10/27/15 =87/52

The mayoclinic.org website stated low blood pressure reading of 90 systolic (the higher number) or a diastolic (the lower number) reading of less than 60 is generally considered low blood pressure.

On 11/18/15 at 825 AM, Nurse C administered several medications to the resident and the resident took pills one at a time.

On 11/19/15 at 4:00 PM, Nurse N verified the lack of nursing documentation of follow up for the 2 abnormal blood pressures.

On 11/19/15 at 4:05 PM, Administrative Nurse A

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F 329	Continued From page 27 verified nursing should report, to the physician, a blood pressure that is so low. He/she stated the physician had not ordered blood pressure parameters until 11/3/15, after the abnormal blood pressures.Administrative Nurse A stated the nurse should have reassessed the resident after staff obtained the low blood pressure readings. The facility's blood pressure taking policy directed staff to measure the resident's blood pressure as physician ordered and record the blood pressure in the resident's chart. The facility failed to provide further monitoring after Resident #8 had 2 abnormal blood pressures.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 16 residents. Based on observation and interview the facility failed to distribute and serve food under sanitary conditions for the 30 residents who eat in 1 of 1	F 371		

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F 371	Continued From page 28 dining rooms. Findings included: - On 11/16/15 at 11:50 AM, observation revealed, during the noon meal service, Nurse Aide E, placed his/her thumbs on the edge of several residents' plates. Further observation revealed Nurse Aide E touched the end of Resident #6's straw with his/her ungloved fingers then placed the straw in the resident's mouth. On 11/16/15 at 11:51 AM, observation revealed, during the noon meal service, multiple staff touched the top of several residents' coffee cups and dessert cups. On 11/16/15 at 12:05 PM, observation revealed, during the noon meal service, Nurse Aide P used Resident #6's soiled clothing protector to wipe jello from the resident's mouth. The facility failed to distribute and serve food under sanitary conditions to the 30 residents who reside in the facility.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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	17E183	A. BUILDING _____ B. WING _____	11/24/2015

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in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 16 residents. Based on observation, record review and interview, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection, by improper hand hygiene when providing care for Resident #12 and #36, improper hand hygiene after providing perineal care for Resident #1, who had clostridium difficile (contagious bacteria

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characterized by foul smelling frequent bowel movements), improper cleaning of the clostridium difficile room, and improper hand hygiene when providing care for Resident #11, who had (VRE) Vancomycin Resistant Enterococci in his/her urine.

Findings included:

- On 11/18/15 at 8:46 AM, Nurse Aide J provided perineal care to Resident #12 who had been incontinent of urine and bowel and with same soiled gloves on, turned resident from side to side. Nurse Aide J fastened the clean incontinent brief and pulled down the resident's shirt with the same soiled gloves.

On 11/18/15 at 9:20 AM, observation revealed Nurse Aide E assisted Resident #1 into the bathroom and pulled down the resident's brief soiled with bowel movement, placed the soiled brief in the trash and removed the resident's pants. Further observation revealed loose bowel movement on the resident's inner left leg which Nurse Aide E cleansed with a wash cloth, with the same soiled gloves, Nurse Aide E obtained a clean wash cloth from the towel bar, next to the sink, removed his/her soiled gloves, and applied clean gloves. Further observation revealed Nurse Aide E moistened the soiled wash cloth, cleansed the resident's inner leg, placed a paper towel on the floor and placed the wet, soiled cloth on the paper towel. Nurse Aide E applied new gloves, provided incontinent care to the resident, and assisted the resident to stand by holding onto his/her gait belt with the soiled gloves on. Nurse Aide E, with the soiled gloves on, pulled up the resident's brief and pants, retrieved the wheelchair, and assisted the resident to the

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wheelchair by holding onto the gait belt. Further observation revealed Nurse Aide E, with the same soiled gloves on, pushed the resident in the wheelchair to his/her recliner, assisted the resident into the recliner while holding onto the gait belt, and used the recliner control to raise the resident's feet. Nurse Aide E retrieved the foam bed mattress from the floor, placed it underneath the resident's feet, and placed the call light within the resident's reach wearing the same soiled gloves.

On 11/18/15 at 11:54 AM, observation revealed Nurse Aide E emptied Resident #36's urine from the a catheter bag, operated the lift control to lift the resident into a wheelchair, with same soiled gloves, then placed the resident's catheter bag in a cover on the bottom of the wheelchair. Further observation revealed Nurse Aide E using the same soiled gloves, straightened the resident's bed linens, put foot pedals on the wheelchair, applied a knitted blanket on the resident's lap, and placed the resident's nasal cannula on his/her face.

On 11/19/15 at 8:40 AM, observation revealed Housekeeping Staff M cleaned the room of Resident #1 who had clostridium difficile. Housekeeping Staff M did not wipe the surface of the rail against the wall, headboard, footboard and bottom side of alarm pads. Further observation of Housekeeping Staff M revealed he/she wiped the bedside table surface around the items which rested on it, took the cloth and rewet it with disinfectant and entered the bathroom. Housekeeping staff M wiped the grab bars, glove box, paper towel dispenser, sink top and faucets, inside and outside of toilet bowl, underside and top of seat. Further observation

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revealed a bottle of bleach cleaner on the floor, in the middle of the room, by the door.

On 11/19/15 at 9:21 AM, observation revealed Nurse Aide P and E used the sit to stand lift to transfer Resident #1, who had clostridium difficile, from the wheelchair to the shower chair. Observation revealed the resident voided a small amount of urine on the floor when staff moved the resident to the shower chair. Nurse Aide P used a personal care wipe to clean the urine off the floor. Nurse Aide P provided perineal care to the resident and with same soiled gloves on, handled the sit to stand lift.

On 11/19/15 at 9:10 AM, observation revealed Nurse Aide E provided perineal care to Resident #11, who had VRE, and with same soiled gloves on, pulled up the resident's pants, removed soiled gloves and did not wash his/her hands prior to leaving the resident's room.

On 11/19/15 at 8:50 AM, Housekeeping Staff M verified the bleach bottle sitting on the floor was contaminated and he/she did not clean it with an appropriate cleaner before placing the bottle back into the housekeeping cart. Housekeeping Staff M verified he/she incorrectly cleaned the toilet bowel.

On 11/19/15 at 2:10 PM, Nurse Aide E stated staff should wash their hands prior to leaving a resident ' s room after contact with the residents.

On 11/19/15 at 4:30 PM, Administrative Nurse A verified staff should wash their hands prior to leaving a resident's room and change gloves after providing perineal care to residents.

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F 441	Continued From page 33 The 3/2012 facility's Hand washing policy stated staff were to wash their hands before and after patient contact, before putting on gloves and after removing gloves, after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient, and with specified procedures. The facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection, by improper hand hygiene after providing perineal care for Residents #12, #36, Resident #1 who had clostridium difficile and Resident #11 who had Vancomycin Resistant Enterococci in urine, and improper cleaning of the clostridium difficile room.	F 441		